Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KINETIC CLINIC
SUITE 750
4151 SOUTHWEST FREEWAY
HOUSTON TX 77027

Respondent Name
FIREMENS INSURNACE COMPANY

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-12-3149-01

MFDR Date Received
June 19, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We respectfully disagree with the denial for payment for the mentioned dates of service. 12/10/10 twic [sic] 41 approved Dr. Thai Nguyen DC as a treating Physician for [injured employee]... Attached post surgical treatment guidelines treatment period 6 months."

Amount in Dispute: $810.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has disputed that the services were reasonable and necessary to treat the compensable injury. Accordingly, this dispute is not properly submitted for fee dispute review. This matter should be dismissed."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 29, 2011 through January 15, 2012	99214	$795.00	$0.00
January 15, 2012	99080-73	$15.00	$15.00
		$810.00	$15.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §129.5 sets out the procedures for completing and filing a Work Status Report.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 216 – Based on the findings of a review organization
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - Note: No substantial change in work status or substantial change in activity restrictions from previous DWC-73 report. DWC-73 is not reimbursable per rule 129.5 (D)(2)

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
3. Did the requestor complete the Work Status Report pursuant to 28 Texas Administrative Code §129.5?
4. Is the requestor entitled to reimbursement for CPT codes 99080-73?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   28 Texas Administrative Code §133.307(e) (3) (G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General).

   The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for CPT codes 99214 for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.
2. The requestor has failed to support that CPT codes 99214 are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307 and therefore, are ineligible for medical fee dispute resolution review.
3. Per 28 Texas Administrative Code §129.5 "(d) The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status;(2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee."

   Per 28 Texas Administrative Code §129.5 "(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

The requestor seeks reimbursement for CPT code 99080-73 rendered on; July 29, 2011, September 6, 2011, October 4, 2011, November 2, 2011, December 2, 2011 and January 15, 2012.

Review of the submitted documentation (DWC-73) for dates of service July 29, 2011, September 6, 2011, October 4, 2011, November 2, 2011 and December 2, 2011 do not document a change in work status or substantial change in activity restrictions, therefore reimbursement cannot be recommended for these dates of service.

Review of the submitted documentation (DWC-73) for date of service January 15, 2012 documents both a change in work status and a substantial change in activity restrictions, therefore reimbursement is recommended in the amount of $15.00 for this date of service.

4. The division finds that the requestor is entitled to reimbursement for CPT code 99080-73 rendered on January 15, 2012 in the amount of $15.00. The division finds that the requestor is not entitled to reimbursement for CPT codes 99080-73 rendered on July 29, 2011, September 6, 2011, October 4, 2011, November 2, 2011 and December 2, 2011.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $15.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 9, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).